PART II—SOME ISSUES IN EVALUATING THE QUALITY OF NURSING CARE

Avedis Donabedian, M.D., M.P.H., F.A.P.H.A.

THE task here is to call attention to certain issues of general import that are raised by the particular approach to the assessment of the quality of nursing care used in the preceding paper. This review will be brief because this author has dealt at greater length with these issues in other publications.[1-3]

Responsibility for the Quality of Care

Very properly, Miss Phaneuf begins with the need for assumption of responsibility for, and a commitment to, the quality of care. Without this foundation stone, the structure of quality assessment cannot be built.

Having accepted responsibility for the quality of care, there still remains a decision about the level and scope of agency concern. One may distinguish several steps in a progression of widening concern.

1. The care provided by a specified professional group (in this case, nursing) in a particular agency.
2. That portion of patient care provided by a particular agency, including the contribution of all professionals involved in the care of any given patient.
3. The total care of any given patient irrespective of the source of care.
4. The provision of health services for the community (however defined) as a whole.

It is necessary to explicitly specify the level and scope of concern because the aspects of care that require assessment may vary from level to level and so may the methods best suited for their assessment. For example, the degree of access to care is an essential concern at the community level; it is much less relevant when the question asked is whether a patient already under care receives quality nursing.

Approaches to Evaluation

There are a set of issues that concern the selection among available approaches to evaluation. One may classify these approaches under three headings: structure, process, and outcome.

The evaluation of *structure* consists in the appraisal of the instrumentalities of care and of their organization. It includes the properties of facilities, equipment, manpower, and financing. It is the major approach used in drawing specifications for assessment, certification or accreditation by official and voluntary agencies. It assumes that when certain specified conditions are satisfied good care is likely to follow.

The evaluation of *process* consists in the appraisal of the care itself. The nursing audit is an example of this approach. It is not satisfied with the mere presumption of quality in any specified setting. It subjects to professional judgment the elements and details of care. It puts to actual test the assumptions that certain structural characteristics are related to certain levels of performance.

The evaluation of *outcomes* consists in the assessment of the end results of care—usually specified in terms of patient health, welfare, and satisfaction. The extent to which agreed-upon desired outcomes are achieved is the ultimate test of the assumptions inherent

in the use of structure and of process in the assessment of care.

Among professionals, one finds much difference of opinion as to which of the three approaches one should use. In particular, there almost always appear to be two camps: those who favor process and those who favor outcome. Following are some observations concerning this division.

1. Whether one emphasizes outcome or process depends on the nature of agency responsibility and the questions that the agency feels required to ask. If the question is "Does the patient receive good nursing care?" the most direct answer would seem to derive from an examination of the process of care. If the question is "What good, if any, are we doing?" the answer is obviously to be found in the outcomes of care.

2. The distinction between process and outcome is, to some extent, an abstraction. Between the initiation of care and its termination there are a number of completed tasks ("procedural end points") and states of the patient ("intermediate outcomes") that can be used as indicators of the quality of care.

3. A well-rounded system of quality appraisal would probably include concurrent or coordinate assessments of structure, process, and end results, to the extent that each of these is observable and measurable under the constraints inherent in any given setting.

Some Technical Issues in the Evaluation of Process

There are a number of technical problems and issues in the nursing audit that can be only briefly mentioned.

1. *The Record as a Source of Information*—One objection to audits, whether medical or nursing, is that they assess the quality of the record rather than that of the care actually provided. Skillful recording may give a false impression of quality, and omissions from the record may convey a false impression of poor care. The record is, of course, an indispensable tool of patient management and it is perfectly legitimate to evaluate the quality of recording. The doubts that are cast on the record as a true mirror of the care actually provided are probably exaggerated; but they have never been fully erased. There are a number of precautions that may be taken to minimize possible misrepresentation by the record. The most important are to devise appropriate records, to enforce reasonable standards of recording, and to allow for discussion of the findings with the person who has provided care.

2. *Definitions, Criteria and Standards*—It is extraordinarily difficult to define what quality is. Very probably quality is not a homogeneous property but a large bundle of characteristics. Certainly clients, physicians, and nurses may look for different characteristics as signifiers of quality and/or weight them differently. As a prelude to any evaluation it is necessary, therefore, to arrive at some agreement concerning what aspects of care are to be assessed and on what constitutes "goodness" in each aspect. The criteria and standards that embody these judgments are operational definitions of quality for any particular method of assessment.

Criteria and standards are implicit in any judgment of quality. The extent to which these are made explicit may, however, vary. Some authorities in medical audits favor explicit formulation of criteria and considerable specificity in standards. Others favor a more unstructured approach in which expert judges are simply guided by how they themselves would have managed a given patient. A cursory review of the nursing literature suggests that nurses are much more systematic and self-conscious in developing quality criteria. In contrast to studies of physician care that focus on purely technical performance, there is also greater attention to social and psychological aspects of patient management.

The nursing audit described by Phaneuf uses a framework of nursing functions to specify in considerable detail what the criteria should be. But it

leaves to the reviewers to judge the extent to which nursing care has measured up to professional standards in each of the characteristics that are specified.

3. *Scales and Measurements*—Some students of quality have a preference for over-all ratings with a minimum of divisions such as "good," "fair," or "poor." Others have assigned numerical scores to elements of care and cumulated them to arrive at an over-all numerical representation of the quality of care. The nursing audit is an example of the latter approach.

In either case, but especially in the second, there are certain vexing problems of measurement. Since quality appears to include a multiplicity of elements or characteristics, the question arises as to whether the scores for these elements can be legitimately combined into one over-all measure and in what way. Such cumulation is made difficult for at least two reasons. First, performance in one aspect of care may not be independent of performance in another. For example, treatment depends on antecedent diagnosis. In extreme cases, performance in one element may be so bad that it cannot be compensated for by excellence in other elements, and the care must be rated "poor." Second, it is difficult to defend the weights (whether equal or unequal) that are assigned to different components or elements of care.

3. *Validity and Reliability*—We have already suggested that the validity of the assessments of process can be tested by determining the outcomes of care. This is the standard procedure in clinical research. It is seldom, if ever, used in quality assessments. The validity of assessments of care rests largely on agreed-upon professional judgment. The reliability or repeatability of judgments using any given method of assessment is easier to test and should be part and parcel of the development of that method. There is reason to believe that reasonably reliable judgments can be obtained through the audit of medical records. It is also claimed that reliability is improved by the prior specification of criteria and standards. Nevertheless, more attention needs to be given to establishing reliability in the assessment of patient care.

Some Operational Issues in the Nursing Audit

There are a number of issues that pertain to the implementation of professional care audits in general.

1. *Who Should Conduct Them and for What Purpose?*—There is general agreement that each profession is solely competent to judge the quality of care provided by its members. However, as the concern broadens to include the total care of individual patients it will become necessary to develop methods that require joint assessment by representatives of several professions.

A second question is whether the audits should be internal, conducted by agency personnel, or external, conducted by persons from outside the agency that is under examination. There is some evidence to suggest that external auditors tend to be more critical than are internal auditors. However, experience has shown that both internal and external audits can be effective. A "mixed" audit committee as proposed by Miss Phaneuf may combine the advantages of both.

The purposes of the audit are recognized to be primarily educational and constructive rather than punitive or destructive. Some authorities have suggested that this preferred orientation be institutionalized by confining the analysis to the identification of pervasive patterns of agency performance. Under this approach, individual physicians or nurses would not be identified or called to question, and the emphasis would

be on altering general patterns of professional behavior. This proposal would seem to limit unduly the administrative usefulness of the professional audit.

2. *Implementation and Effectiveness*—There has been remarkably little study of the ability of professional audits to bring about lasting changes in professional behavior. There have been anecdotal accounts of remarkable success and of abject failure; but little is known about the circumstances that determine success or failure. There is urgent need for studies of the professional audit primarily as a complex social process rather than merely a technical problem of measurement.

3. *Cost, and Cost in Relation to Effectiveness*—Data on the cost of audits are almost nonexistent. Nor are there any data on cost in relation to effectiveness of audits or of alternative methods of appraisal. Such studies are sorely needed.

Findings

The findings reported by Miss Phaneuf show significant weaknesses in performance even in a prestigious agency such as the one studied. These findings are in keeping with the more extensive reports of physician care. These have shown serious problems in almost every study reported. There have been significant failings in management even in university-affiliated institutions. Where technical error is considerably reduced, failures in the nontechnical dimensions of care become more salient. It is clear that the quality of care cannot be taken for granted. It must be carefully maintained and nurtured. Furthermore, as the prevailing levels of quality improve, the standards by which quality must be judged become more rigorous and demanding. To that extent, the quest for quality can never end.

REFERENCES

1. Donabedian, A. Evaluating the Quality of Medical Care. Milbank Mem. Fund Quart. 44:166-206, Part 2 (July), 1966.
2. ————. Promoting Quality Through Evaluating the Process of Patient Care. M. Care 6:181-202 (May-June), 1968.
3. ————. A Guide to Medical Care Administration, Volume II, Medical Care Appraisal—Quality and Utilization. New York: The Program Area Committee on Medical Care Administration, American Public Health Association (Aug.), 1968 (to be published).

Dr. Donabedian is Professor of Medical Care Organization, University of Michigan School of Public Health, Ann Arbor, Mich. 48109

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